TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STEVE SACKS, MD

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-15-3554-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JUNE 25, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Liberty Mutual on 10-16-14, this request was in response to A $755.25 reduction of the $1039.37 for the EMG performed on 8-7-14. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $755.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The office visit of August 7, 2014 was denied because the documentation does not support the level of service billed. Note that the interpretation of EMG/Nerve Conduction procedures is included in the professional component of the procedure. The same service cannot be applied to fulfillment of requirements for more than one code. This would result in double payment. Code A4556 is a supply charge which is not separately payable under Medicare guidelines."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 7, 2014	CPT Code 99204 New Patient Office Visit	$255.66	$0.00
	CPT Code 95886 (X2) Needle EMG	$0.00	$0.00
	CPT Code 95913 Nerve Conduction Studies (13 or more)	$474.59	$0.00
	HCPCS Code A4556 Electrodes	$25.00	$0.00
TOTAL		$755.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X457-No significant identifiable evaluation and management service has been documented.
   - X901-Documentation does not support level of service billed.
   - U630-Procedure code not separately payable under Medicare and-or fee schedule guidelines.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

Issues

1. Does the documentation support billing CPT code 99204?
2. Does the documentation support billing CPT code 95913?
3. Is the benefit for HCPCS code A4556 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for HCPCS code A4556?

Findings

1. According to the submitted explanation of benefits, the respondent denied payment for CPT code 99204 based upon reason code "X457."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines code 99204 as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

   The Division finds that the requestor's documentation did not support a comprehensive history or medical decision making of moderate complexity. In addition, a separate evaluation and management report was not submitted; therefore, the respondent's denial is supported. As a result reimbursement is not recommended.

2. The respondent denied reimbursement for CPT code 95913 based upon reason code "X901."

CPT code 95913 is defined as "Nerve conduction studies; 13 or more studies." A review of the requestor's report supports 10 studies; therefore, the requestor did not support level of service billed. As a result, no reimbursement is recommended.

3. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4556 based upon reason code "U630".

   HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

   Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		07/24/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.